

VR A.15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13794											
CERTIFICATE OF DEATH											
13798											
1. PLACE OF DEATH a. COUNTY Dorchester						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b about 50 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				d. STREET ADDRESS 708 Church Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CECIL Middle KEENE Last APPLEGARTH						4. DATE OF DEATH Month Oct. Day 1, Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892 Sept. 15, 1922		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec Appliance Sales				10b. KIND OF BUSINESS OR INDUSTRY Retail Merchant		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Applegarth						14. MOTHER'S MAIDEN NAME Annette Keene					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk				16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Harold G. Applegarth, Cambridge, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subtotal gastric resection for benign ulcer Sept 24, 1967 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 67 , to Oct 1 , 19 67 , that (I) (we) last saw the deceased alive on Oct 1 , 19 67 , and that death occurred at 9 M, from the causes and on the date stated above.											
22a. SIGNATURE Lewis M. Burdette						22b. DATE SIGNED 3 Oct 67			22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette 4 Aurora St. Cambridge Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Star Of The Sea Cemetery		23d. LOCATION (City, town or county) (State) Golden Hill, Dor. Co., Md.			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR Oct 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13795

13799

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Cambridge Maryland Hospital			d. STREET ADDRESS 313 Oakley Street		
3. NAME OF DECEASED (Type or print) First HAROLD Middle PIERRE Last APPLEGARTH			4. DATE OF DEATH Month Oct. Day 26 Year 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1925	9. AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months 41 Days 41 Hours 41 Min. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	
13. FATHER'S NAME Harold G. Applegarth			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			14. MOTHER'S MAIDEN NAME Imogene Seward		
16. SOCIAL SECURITY NO. None			17. INFORMANT Harold G. Applegarth, Cambridge, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cranial injury DUE TO Multiple skull fractures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Multiple skull fractures DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Instant Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding bicycle, head on collision with auto.			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 7 PM p.m. 10/26/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Cambridge, Dor. Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr.		M.D.		22. DATE SIGNED 10/27/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Star Of The Sea Cemetery	23d. LOCATION (City or Town) (County) (State) Golden Hill, Dor. Co. Md		
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

12700

1074

For name

For name

For name

Life

Life

310 Center Street

1001 Riverside Boulevard

Oct. 25, 1932

APPROPRIATE

RECEIVED

RECEIVED

RECEIVED

Nov. 21, 1932

Nov. 21, 1932

U. S. National Bank

U. S. National Bank

U. S. National Bank

U. S. National Bank

U. S. National Bank

U. S. National Bank

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U. S. National Bank

U. S. National Bank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13796
CERTIFICATE OF DEATH
13800

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS 107 Somerset Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond T. Applegarth		4. DATE OF DEATH Month Day Year Oct. 21, 1967 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1886
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) County tax assessor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cambridge, R.D.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas S. Applegarth		14. MOTHER'S MAIDEN NAME Ettie M. Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Address 107 Somerset Ave. Mrs. Eva C. Applegarth, Cambridge, Md.	
17. INFORMANT Mrs. Eva C. Applegarth, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding duodenal ulcer, Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1967, to Oct 21, 1967, that (I) (we) last saw the deceased alive on Oct 20, 1967, and that death occurred at 2:45 PM from the causes and on the date stated above.	
22a. SIGNATURE Lewis M. Burdette		22b. DATE SIGNED Oct 21, 1967	
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette		22d. ADDRESS 4 Aurora St, Cambridge Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Kenneth A. Thomas		25a. REC'D BY REGISTRAR DATE OCT 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

6252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13801									
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 205 Washington St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First John Middle Jacob Last Arnie			4. DATE OF DEATH Month Oct. Day 24 Year 1967						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 10, 1885		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Merchant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Monroe, Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John J. Arnie					14. MOTHER'S MAIDEN NAME Sophia Beyer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-36-6751		17. INFORMANT Mrs. Grace M. Arnie, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10-23 , 19 67 , to 10-24 , 19 67 , that (I) (we) last saw the deceased alive on 10-24 , 19 67 , and that death occurred at 11:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE [Signature] M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-26-67		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 27, 1967		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City, town or county) (State) East New Market, Md.		
24. FUNERAL DIRECTOR Kenneth R. Thomas					ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR NOV 3 1967		25b. REGISTRAR'S SIGNATURE [Signature]

1900

1900

Oct. 11, 1900

NOV 1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13798

13803

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brookview		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle V. Last BELL		4. DATE OF DEATH Month October Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30, 1877
9. AGE (In years lost birthday yrs.) 90		10. IF UNDER 1 YEAR Months 1 Days 15 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. D. Adams		14. MOTHER'S MAIDEN NAME Josephine Willey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT J. Peyton Adams, Rhodesdale, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , to Oct 15, 1967 , that (I) (we) last saw the deceased alive on Oct 14, 1967 , and that death occurred at 4 P. M. from causes and on the date stated above.			
22a. SIGNATURE H.S. Kuhlman		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) H S Kuhlman		22d. ADDRESS Sharpton Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery	23d. LOCATION (City or Town) (County) (State) Brookview, Maryland
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR DATE OCT 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

10234

CHARTER OF 1871

1871

Dorchester

Marshall

Dorchester

Brookdale - Rural

LA 10

Brookdale - Rural

Brookdale

Brookdale

ALBERTA

WILL

October 12

September 30, 1877

Fernie

Hogswater

Hogswater

Dorchester Co., Va.

USA

James E. D. Adams

Alphonso Willey

1. Peyton Adams, Brookdale, Va., NY

No. 1

Final: Oct. 17, 1897 - Brookline Cemetery

J. J. Thompson and Son, Brookline, Maryland

Oct 20, 1897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13799											
13804											
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bishops Head d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HERBERT Middle C. Last BRAMBLE						4. DATE OF DEATH Month Oct. 5, 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1891		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Moses W. Bramble						14. MOTHER'S MAIDEN NAME Minnie Dayton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 1				16. SOCIAL SECURITY NO. unk		17. INFORMANT Mrs. Herbert C. Bramble, Bishops Head, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG - METASTASES TO ADRENAL DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (U) (this hospital) attended the deceased from 9-8, 1967 , to 10-5, 1967 , that (U) (we) last saw the deceased alive on 10-5, 1967 , and that death occurred at 9:30 p.m. from the causes and on the date stated above.											
22a. SIGNATURE James F. McArthur						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-7-67			
22c. PHYSICIAN'S NAME (Type) JAMES F. MCARTHER, M.D.						22d. ADDRESS Box 386 Cambridge, Md. 21613					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct 8, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery			23d. LOCATION (City, town or county) (State) Bishops Head, Dor. Co., Md.			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						ADDRESS		25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13752

Dorchester

Cambridge

Dorchester, Dorchester Hospital

Warrant

X

White

Male

Carlton

Section

House, 1, 1/2

Minister, Devon

Yes

by 1

Wm

Mr. Herbert G. Henshaw, Cambridge, Massachusetts

1910-1911

Oct 5, 1907 St. Thomas Cemetery

Burial

Isaacson Funeral Service, Cambridge, Maryland

1910-1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13800 Item 3 Film 6100 10/14/67 13805											
MARYLAND STATE DEPARTMENT OF HEALTH											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital						d. STREET ADDRESS 719 Race Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle V. ASPLEN Last BROHAWN						4. DATE OF DEATH Month Oct. Day 5 Year 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1885		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Otho J. Asplen						14. MOTHER'S MAIDEN NAME Ada Bennett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. unk		17. INFORMANT John J. Brohawn, Cambridge, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial Asthma											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 9-30 , 19 67 , to 10-5 , 19 67 , that (I) (we) last saw the deceased alive on 10-5 19 67 , and that death occurred at 2:30 M, from the causes and on the date stated above.											
22a. SIGNATURE W. N. Baumann						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-4-67			
22c. PHYSICIAN'S NAME (Type) W. N. Baumann, MD						22d. ADDRESS 10 Aurora St., Cambridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park				23d. LOCATION (City, town or county) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

Cambridge, Massachusetts
 100 Brookline Avenue
 Boston, Massachusetts 02115
 Telephone: (617) 552-1234
 Fax: (617) 552-1235
 Email: info@cambridge.edu
 Website: www.cambridge.edu

Cambridge, Massachusetts
 100 Brookline Avenue
 Boston, Massachusetts 02115
 Telephone: (617) 552-1234
 Fax: (617) 552-1235
 Email: info@cambridge.edu
 Website: www.cambridge.edu

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13801

CERTIFICATE OF DEATH

13806

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYDEL	
c. LENGTH OF STAY IN 1b 2 YEARS		d. STREET ADDRESS EASTERN SHORE STATE HOSPITAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle WILMER Last CAIN		4. DATE OF DEATH Month OCT. Day 5 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/70
9. AGE (In years last birthday) yrs. 97		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah Cain		14. MOTHER'S MAIDEN NAME Harriett ***** Pierce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-52-7907T	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Arterial Nephrosclerosis - Uremia		INTERVAL BETWEEN ONSET AND DEATH 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 5, 1965 to October 5, 1967 , that (I) (we) lost saw the deceased alive on October 5, 1967 , and that death occurred at 3:26 P.M. from causes and on the date stated above.			
22a. SIGNATURE Carlos F Barros		22b. DATE SIGNED October 5, 1967	
22c. PHYSICIAN'S NAME (Type) CARLOS F BARROSO		22d. ADDRESS HURLOCK MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-9-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Marydel, Md.
24. FUNERAL DIRECTOR Edward C Stevenson		25a. REC'D BY REGISTRAR Delaware	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 9 1967	

MEDICAL CERTIFICATION

13801

DEPARTMENT OF HEALTH

13-00

DOAGRE STATE

DEPARTMENT OF HEALTH

2 YEARS

1910

CACONIA STATE HOSPITAL

CHARTER

1910

RECORD

1910

CHARTER

1910

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CHARTER

1910

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13802

CERTIFICATE OF DEATH

13807

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK		c. LENGTH OF STAY IN lb 4 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALSBURG
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BELLE HAVEN NURSING HOME		d. STREET ADDRESS OLD DENTON ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last MATTIE DOUGHTY CHRISTOPHER		4. DATE OF DEATH Month Day Year OCTOBER 17 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1887
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY F. ANDREW		14. MOTHER'S MAIDEN NAME A. VICTORIA JESTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-20-6832	
17. INFORMANT MRS. G. W. FLUHARTY, FEDERALSBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cardiac Decompensation DUE TO (b) Arteriosclerotic Cardio Renal Disease DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10yrs 20yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral ataracts Osteoarthritic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/17 , 19 67 , to 10/17/67 , 19 67 , that (I) (we) last saw the deceased alive on 10/13/67 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Harold B. Plummer		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer M.D.		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 21, '67	
23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		23d. LOCATION (City or Town) (County) (State) FEDERALSBURG, CAROLINE, MD.	
24. FUNERAL DIRECTOR FRAMPTON FUNERAL HOME, FEDERALSBURG, MD.		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

5032

8:10 PM

03 5881 71 7840

5232-10-315

U.S. DEPARTMENT OF COMMERCE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylor's Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital (DOA)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Cornish Last		4. DATE OF DEATH Month Oct. Day 11. Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1898
9. AGE (In years lost birthday) yrs. 69		IF UNDER 1 YEAR Months 09 Days 11 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Cornish		14. MOTHER'S MAIDEN NAME Leah James	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-1595	
17. INFORMANT Maggie Bennett		Address Taylor's Island, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 15 Mins	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 10/13/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/67	
23c. NAME OF CEMETERY OR CREMATORY Taylor's Island		23d. LOCATION (City or Town) (County) (State) Dorchester County, Md.	
24. FUNERAL DIRECTOR Fredrick C. Jones		ADDRESS Cambridge, Md.	
25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Memorandum for the President
Subject: [Illegible]
Reference: [Illegible]
[Illegible text follows]

[Illegible text block]

[Illegible text block]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

M

13804

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13809

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 906 Phillips St.		d. STREET ADDRESS 906 Phillips St.	
3. NAME OF DECEASED (Type or print) Thomas First Middle Last L. Davis		4. DATE OF DEATH Month Oct. Day 27 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1900
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 7 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS O. DAVIS		14. MOTHER'S MAIDEN NAME ELEANOR VAUGHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-8010	
17. INFORMANT PETER DAVIS		Address RT 1 EMPORIA, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of bladder DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Cambridge, Md.	
22. DATE SIGNED 11/11/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial		23b. DATE THEREOF 10-31-67	
23c. NAME OF CEMETERY OR CREMATORY Mary Hill		23d. LOCATION (City or Town) (County) (State) Emporia Va	
24. FUNERAL DIRECTOR Hilda West		ADDRESS Salisbury Md	
25a. REC'D BY REGISTRAR DATE OCT 31 1967		25b. REGISTRAR'S SIGNATURE John Mace Jr.	

13400

3204

13400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

13803

CERTIFICATE OF DEATH

13810

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b 2 mons. 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Belle Haven Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IVY Middle BEATRICE Last EGE				4. DATE OF DEATH Month October Day 8 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1887	
9. AGE (In years last birthday) yrs. 80		10. USUAL OCCUPATION (Give kind of work done during rest of working life, even if retired) Housework		11b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Harrisburg, Penna.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Adam Kope			
14. MOTHER'S MAIDEN NAME Elizabeth McLenagan				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Address Nursing Home Records, Hurlock, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Massive Cerebral Hemorrhage DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 12 hours 60 hrs 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/12/67 , 19 to 10/8 , 19 67 , that (I) (we) lost saw the deceased alive on 10/8 , 19 67 , and that death occurred at 2:55 AM from causes on and on the date stated above.							
22a. SIGNATURE <i>Harold B. Pummer</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/8/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Pummer M.D.				22d. ADDRESS Preston Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware	
24. FUNERAL DIRECTOR <i>J. J. Frampton and Son</i>				25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

J. J. Frampton and Son, Federalburg, Maryland

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Abstract

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Writing How Records, Ruckel, Maryland

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Oct. 18, 1967

Silvabrook Cemetery

Received: 2014-07-16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock c. LENGTH OF STAY IN 1b 3 1/2 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belle Haven Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS Academy Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First D'ARCY Middle J. Last FOUNTAIN						4. DATE OF DEATH Month Oct. Day 9, Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 29, 1883		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 09 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk				10b. KIND OF BUSINESS OR INDUSTRY Retail Store		11. BIRTHPLACE (County & State, or foreign country) Cambridge, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John A. Fountain						14. MOTHER'S MAIDEN NAME Wilhelmina Mills					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk				16. SOCIAL SECURITY NO. 220-07-5261		17. INFORMANT Address Mrs. William Shaw, Cambridge, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema 442x DUE TO (b) Chronic Congestive cardio renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mos 10yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Barin Syndrome										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/17.64 , 19, to 10/9/67 , 19, that (I) (we) last saw the deceased alive on 10/8/67 , 19, and that death occurred at 2:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]								22b. DATE SIGNED 10/11/67			
22c. PHYSICIAN'S NAME (Type) Harold B. Blummer M.D.						22d. ADDRESS Preston Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park				23d. LOCATION (City, town or county) (State) Cambridge, Maryland			
24. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland						25a. REC'D BY REGISTRAR Oct 16 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

Reception Funeral Service, Cambridge, Maryland

Oct 1 - 1967

Burial - Col. H. L. 1967, Dorchester Memorial Park, Cambridge, Maryland

Funeral Home, Cambridge, Maryland

Funeral Home, Cambridge, Maryland

Funeral Home, Cambridge, Maryland

Funeral Home, Cambridge, Maryland

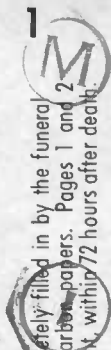
Funeral Home, Cambridge, Maryland

Funeral Home, Cambridge, Maryland

Funeral Home, Cambridge, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13807

13812

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wic</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 5 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>				d. STREET ADDRESS <u>407 N. Division St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Stephen Gates</u>				4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Widow</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>03-15-86</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>67</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman City of Salisbury</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Vermont</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Arthur Gates</u>		14. MOTHER'S MAIDEN NAME <u>Martha Gates</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records</u> Address <u>E. S. S. H.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: <u>4341</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 days</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Diabetic mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 3</u> , 19 <u>65</u> , to <u>October 11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>October 11</u> , 19 <u>67</u> , and that death occurred at <u>120</u> PM, from causes and on the date stated above.							
22a. SIGNATURE <u>Carlos F Barrdso</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>October 11, 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F BARRD SO</u>				22d. ADDRESS <u>HURLOCK Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/14/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>SALISBURY, Wic. Md.</u>	
24. FUNERAL DIRECTOR <u>Hill Funeral Home Salisbury, Md.</u> <u>Norman T. Baker</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13802

13813

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMERIDGE		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARSONSBURG (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS ROUTE 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD DAE E. GILLIS				4. DATE OF DEATH Month Day Year OCTOBER 7 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08-16-94	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11. BIRTHPLACE (County & State, or foreign country) WICOMICO, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN HENRY J. Gillis		14. MOTHER'S MAIDEN NAME EDNA DASHIELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT Address EASTERN SHORE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASPIRATION OF VOMITUS DUE TO (c) CHRONIC CONGESTIVE HEART FAILURE				INTERVAL BETWEEN ONSET AND DEATH 5 MIN. 7 MIN. 5 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) PNEUMONIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 09-30 , 19 67 , to OCT 7 , 19 67 , that (I) (we) last saw the deceased alive on OCT 7 , 19 67 , and that death occurred at 125 PM , from causes and on the date stated above.							
22a. SIGNATURE Sean M. Killoran				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED OCT. 7, 1967	
22c. PHYSICIAN'S NAME (Type) SEAN M. KILLORAN M.D.				22d. ADDRESS EASTERN SHORE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-1967		23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery		23d. LOCATION (City or Town) (County) (State) Mardela, Maryland	
24. FUNERAL DIRECTOR Thomas F. Wallace				ADDRESS Salisbury, Md.		25a. REC'D BY REGISTRAR OCT 11 1967 DATE	
				25b. REGISTRAR'S SIGNATURE John L. Jones			

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CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>13809</div> <div> <div>Item #2 11/11/67</div> <div>13814</div> </div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> </div>									
<div>1. PLACE OF DEATH</div> <div>a. COUNTY Dorchester</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge</div> <div>c. LENGTH OF STAY IN 1b 6 days</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Md. Hospital</div>					<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE Md.</div> <div>b. COUNTY Dor. Ken</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge/ Millington, Md.</div> <div>d. STREET ADDRESS Glasgow Nursing Home/</div> <div>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>				
<div>3. NAME OF DECEASED (Type or print)</div> <div>First Rolland</div> <div>Middle L.</div> <div>Last Gundlach</div>			<div>4. DATE OF DEATH</div> <div>Month Oct.</div> <div>Day 29</div> <div>Year 1967 19</div>						
<div>5. SEX</div> <div>Male</div>		<div>6. COLOR OR RACE</div> <div>W</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>10/1/99</div>		<div>9. AGE (In years last birthday) 68</div> <div>IF UNDER 1 YEAR Months Days Hours Min.</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Retired</div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Farming</div>		<div>11. BIRTHPLACE (State or foreign country)</div> <div>Iowa</div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>	
<div>13. FATHER'S NAME</div> <div>Herman L.C. Gundlach</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Nellie I. Bisby</div>				
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>Unknown No.</div>				<div>16. SOCIAL SECURITY NO.</div> <div>?</div>		<div>17. INFORMANT</div> <div>Records Cambridge Hospital.</div>			
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) Terminal pneumonia</div> <div>9027</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>DUE TO (b) Fracture neck r. femur</div> <div>DUE TO (c)</div> <div>INTERVAL BETWEEN ONSET AND DEATH 3 days</div> <div>6 days</div>									
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>									<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>Fell out of bed.</div>					
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year 10/23/67</div> <div>Hour a.m. 11 AM</div>			<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>Nursing Home</div>		<div>20f. (City or town) (County) (State)</div> <div>Cambridge Dor. Md.</div>		
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>									
<div>ACTUAL SIGNATURE</div> <div>John Ma ce Jr.</div>					<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div> <div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div> <div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div> <div>22. DATE SIGNED 10/29/67</div>				
<div>EXAMINER'S NAME (Type)</div> <div>John Ma ce Jr.</div>			<div>Address (Street, city, town, or county)</div>						
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>			<div>23b. DATE THEREOF</div> <div>Nov. 1, 1967</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Sudlersville Cemetery</div>		<div>23d. LOCATION (City, town or county) (State)</div> <div>Sudlersville, Q.A.Co; Md.</div>		
<div>24. FUNERAL DIRECTOR</div> <div>Edward Fellows & Son,</div>					<div>ADDRESS</div> <div>Millington, Md. 21651</div>				
<div>25a. REC'D BY REGISTRAR</div> <div>OCT 31 1967</div>					<div>25b. REGISTRAR'S SIGNATURE</div> <div>J Charles Judge</div>				

1941

1941

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

WASHINGTON, D. C.

Division of Public Health

Section of Public Health

Office of the Assistant Secretary for Public Health

Washington, D. C.

Division of Public Health

Section of Public Health

Office of the Assistant Secretary for Public Health

Washington, D. C.

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Washington, D. C.

Division of Public Health

Section of Public Health

Office of the Assistant Secretary for Public Health

Washington, D. C.

Division of Public Health

Section of Public Health

Office of the Assistant Secretary for Public Health

Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>					d. STREET ADDRESS <u>Main</u>				
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Rosalin</u> Last <u>Helsby</u>					4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/24/1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework - own home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eben Wheatley</u>					14. MOTHER'S MAIDEN NAME <u>Huldah Cootee</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>				
17. INFORMANT <u>Mrs. William Smith, Baltimore, Md.</u>					Address <u>—</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation c Ventricular</u> DUE TO (b) <u>Chronic Congestive Heart Disease</u> DUE TO (c) <u>Arteriosclerotic Cardio Renal Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 mos</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>47</u> , to <u>10-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> , 19 <u>67</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Harold B. Plummer</u> M.D.					22b. DATE SIGNED <u>10/3/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer</u>					22d. ADDRESS <u>Preston Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town or county) (State) <u>East New Market, Md</u>			
24. FUNERAL DIRECTOR <u>Ruth S. Mulloghby</u>					25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>				
DATE <u>OCT 9</u> 19 <u>67</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13811
13816
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b about 45 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 405 Must Street			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle MAY Last HUBBARD				4. DATE OF DEATH Month Oct. Day 25 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1885	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William M. Reed				14. MOTHER'S MAIDEN NAME Ellen M. Paul			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218-20-7533A		17. INFORMANT Mr. Eldridge Hubbard, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Arthritis				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11-11-61 19 to 10-25-67 19, that (I) (we) last saw the deceased alive on 10-24-67 19, and that death occurred 7:20AM from the causes and on the date stated above.							
22a. SIGNATURE Albert E. Bunker				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-27-67	
22c. PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.				22d. ADDRESS 200 Md.Ave., Cambridge, Md. 21613			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE James J. George	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>2. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN It <u>3 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>		e. STREET ADDRESS <u>Chesterfield Ave,</u>	
3. NAME OF DECEASED (Type or print) <u>Martha Covey Hunter</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>11</u> Year <u>1967</u>	
5. SEX <u>W</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-25-74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Robert Davis</u>		14. MOTHER'S MAIDEN NAME <u>SARAH DAVIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-4761-J1</u>	
17. INFORMANT <u>E.S.S.H - Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Senile Cachexia</u>			
DUE TO			
(b) <u>794x</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-09</u> , 19 <u>67</u> , to <u>10-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>67</u> , and that death occurred at <u>1 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Efrain C. Fernandez</u>		22b. DATE SIGNED <u>10-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EFRAIN C. FERNANDEZ</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Oct. 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Centreville P. A. Co. Md.</u>
24. FUNERAL DIRECTOR <u>James H. Barton</u>		25a. READ BY REGISTRAR <u>J. Barton</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
ADDRESS <u>Centreville, Md.</u>		DATE <u>OCT 16 1967</u>	

1915

REPORT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13813

CERTIFICATE OF DEATH

13818

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS 308 Shepherd Ave.	
3. NAME OF DECEASED (Type or print) First Major Middle Allen Last Hurley		4. DATE OF DEATH Month Oct. Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1878
9. AGE (in years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 08 Days 1	
11. IF UNDER 24 HRS. Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Hurley		14. MOTHER'S MAIDEN NAME Gertrude Horseman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. W. Walton Fitzhugh, Cambridge, Md.		Address 313 Shepherd Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hours Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-29 , 19 67 , to 10-30 , 19 67 , that (I) (we) last saw the deceased alive on 10-30 , 19 67 , and that death occurred at 3:35 PM, from the causes and on the date stated above.			
22a. SIGNATURE Richard G. Bilodeau		22b. DATE SIGNED 10-31-67	
22c. PHYSICIAN'S NAME (Type) RICHARD G. BILODEAU		22d. ADDRESS CITY OFFICE BLDG., CAMBRIDGE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cambridge		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Levinth R. Thomas		25a. REC'D BY REGISTRAR NOV 3 1967	
ADDRESS Cambridge		25b. REGISTRAR'S SIGNATURE Charles Judge	

13-12

STATE OF TEXAS

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County of *Andrew*
State of *Texas*

1913-12-12

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RICHARD G. BLOOM

Agent for the

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MB. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13814

13819

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY in 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS 1003 Hambrooks Blv'd.		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First JOHN Middle HERMAN Last INSLEY				4. DATE OF DEATH Month Oct. Day 26 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1885		9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months 0 Days 9 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Waterman Ret.		10b. KIND OF BUSINESS OR INDUSTRY Dirt-Seafood		11. BIRTHPLACE (State or foreign country) Toddville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hutz Insley				14. MOTHER'S MAIDEN NAME Elizabeth Rebecca Lloyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-8866		17. INFORMANT Address Mrs. J. Herman Insley, Cambridge, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____						INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr. M.D.				22. DATE SIGNED 10/27/67 Address (Street, city, town, or county) Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR DATE OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13815

CERTIFICATE OF DEATH

13820

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b Hurlock			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Lesia Middle Ann Last Johnson		4. DATE OF DEATH Month October Day 19 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1967		9. AGE (In years lost birthday) yrs. 13	IF UNDER 1 YEAR Months 47	IF UNDER 24 HRS. Hours 13 Min. 47
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Dorchester; Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Winfield Johnson				14. MOTHER'S MAIDEN NAME Betty Maxnice Spry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Hurlock, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress syndrome DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-19-67 8:47 a.m. to Oct 19 12:47 p.m. , that (I) (we) last saw the deceased alive on Oct 19 19 67 , and that death occurred at 10:02 P.M. from causes and on the date stated above.							
22a. SIGNATURE [Signature]				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10- 20- 67	
22c. PHYSICIAN'S NAME (Type) D. J. Edwin Fassett				22d. ADDRESS 623 High Street; Cambridge, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-21-67		23c. NAME OF CEMETERY OR CREMATORY Federalsburg, cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg	
24. FUNERAL DIRECTOR Frampton				ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR OCT 24 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]			

01251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					c. LENGTH OF STAY IN 1b 6 months				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital					d. STREET ADDRESS Rural				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Grace Middle Insley Last Jones					4. DATE OF DEATH Month Oct. 13 , 1967 Year 19				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1883		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Crapo, Dorchester Co., U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Corbin Insley					14. MOTHER'S MAIDEN NAME Arianna Mister				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT Cambridge, Md. W. Paul Jones, 10 Bellevue Ave.,									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 120 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastroenteritis									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9-11 , 1967, to 10-13 , 1967, that (I) (we) last saw the deceased alive on 10-9 , 1967, and that death occurred at 4:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Richard B. Bilodeau					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-16-67		
22c. PHYSICIAN'S NAME (Type) RICHARD B. BILODEAU					22d. ADDRESS CITY OFFICE BLVD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Jones Family Cemetery		23d. LOCATION (City, town or county) (State) Toddville, Md.		
24. FUNERAL DIRECTOR Henneth R. Thoreau					ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR OCT 19 1967		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

1958

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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13817

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13822

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN life life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 622 High St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oliver Meekins		4. DATE OF DEATH Month October Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. EATHER'S NAME Charles Meekins Sr.		16. MOTHER'S MAIDEN NAME Emma Chester	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. 214-07-9447	
19. INFORMANT Emma Wilson		Address Cambridge, Md.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 331X IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	24d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	25e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	26f. (City or town) (County) (State)
27. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		28. DATE SIGNED 11/2/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		29. ADDRESS (Street, city, town, or county) Cambridge, Md.	
30a. BURIAL, CREMATION, REMOVAL (Specify) Burial	31b. DATE THEREOF 11/2/67	32c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	33d. LOCATION (City or Town) (County) (State) Golden Hill, Dor., Md.
34. FUNERAL DIRECTOR St. Clair Funeral		35. ADDRESS Cambridge, Md.	
36. RECEIVED BY REGISTRAR NOV 6 1967		37. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
CERTIFICATE OF DEATH																			
13819																			
13823																			
1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY DORCHESTER														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSPITAL, INC.					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First GEORGE Middle MURRAY Last MURRAY					4. DATE OF DEATH Month OCTOBER Day 4 Year 1967														
5. SEX MALE		6. COLOR OR RACE NEGROID		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 14, 1889		9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER					10b. KIND OF BUSINESS OR INDUSTRY -----					11. BIRTHPLACE (County & State, or foreign country) DORCHESTER CO., MD.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME HENRY MURRAY					14. MOTHER'S MAIDEN NAME MARY MURRAY														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. 215-18-4657A					17. INFORMANT THELMA M. CORNISH Address WASHINGTON, D.C.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO (b) CARDIAC DECOMPENSATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ARTERIOSCLEROTIC HEART DISEASE										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from Sept. 27, 1967 to OCT. 4, 1967 , that (I) (we) last saw the deceased alive on OCT. 3, 1967 , and that death occurred at ----- M, from causes and on the date stated above.																			
22a. SIGNATURE <i>J. Edwin Fassett</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED OCT. 5, 1967									
22c. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.					22d. ADDRESS 623 High Street, Camb., Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 10/7/67		23c. NAME OF CEMETERY OR CREMATORY Salem			23d. LOCATION (City or Town) (County) (State) SALEM DOR. MD.											
24. FUNERAL DIRECTOR <i>John C. Delain</i>					ADDRESS CAMBRIDGE, MD.					25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE <i>John C. Delain</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

13819				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13824			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HURLOCK							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSPITAL, INC.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First VERA Middle HOPKINS Last MURRAY				4. DATE OF DEATH Month OCTOBER Day 16 Year 19 67							
5. SEX FEMALE	6. COLOR OR RACE NEGROID	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 13, 1891		9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) DORCHESTER CO., MD.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME HARRISON HOPKINS				14. MOTHER'S MAIDEN NAME ELIZBETH BANKS							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16. SOCIAL SECURITY NO. 220-01-7852A		17. INFORMANT Address THELMA H. CORNISH WASHINGTON, D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO (b) Arteriosclerotic cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1967 to Oct. 16, 19 67 that (I) (we) lost saw the deceased alive on October 10, 1967 , and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 17, '67					
22c. PHYSICIAN'S NAME (Type) EDWIN FASSETT, M.D.				22d. ADDRESS 623 HIGH STREET, CAMB., MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/20/67		23c. NAME OF CEMETERY OR CREMATORY SALEM		23d. LOCATION (City or Town) (County) (State) SALEM DOR. MD.					
24. FUNERAL DIRECTOR 				ADDRESS CAMBRIDGE, MD.		25a. REC'D BY REGISTRAR DATE NOV 6 1967					
				25b. REGISTRAR'S SIGNATURE 							

13812

DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13820

13825

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN <u>3 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		d. STREET ADDRESS <u>20-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Lumpkin Nelson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-05-1882</u>
9. AGE (In years lost birth day) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garment Business</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John I. Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Lumpkin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-07-6098</u>	
17. INFORMANT <u>Eastern Shore State Hosp. (Medical Records)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>GENERALIZED ARTERIOSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 6</u> , 19 <u>67</u> , to <u>OCT 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT 9</u> 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Sean M. Killoran M.D.</u>		22b. DATE SIGNED <u>OCT 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/11/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Maurice E. Deeman-Son Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 10 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CHURCH OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captop papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Cambridge d. STREET ADDRESS Paw Paw RFD No. 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle COLLINS Last NIEMAN		4. DATE OF DEATH Month Oct. Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1880
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) St. Michaels, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Collins		14. MOTHER'S MAIDEN NAME Johanna Pfister	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 208-01-6723D	
17. INFORMANT Address Miss Mildred Nieman, RFD 3, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (adeno) of right colon with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) colon with metastases DUE TO (c) months		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 67 , to Oct 6 , 19 67 , that (I) (we) last saw the deceased alive on Oct 6 , 19 67 , and that death occurred at 9 PM , from the causes and on the date stated above.			
22a. SIGNATURE Lewis M. Burdette		22b. DATE SIGNED 9 Oct 67	
22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette		22d. ADDRESS 4 Aurora St, Cambridge Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Old Trinity Cemetery		23d. LOCATION (City, town or county) (State) Church Creek, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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STATEMENT OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13822

13822

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Cambridge Md. Hospital		d. STREET ADDRESS 12 Lincoln Terrace	
3. NAME OF DECEASED (Type or print) Eddie James Patterson		4. DATE OF DEATH Month Oct. Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1938
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ed. Patterson		14. MOTHER'S MAIDEN NAME Ida Watkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-46-0615	
17. INFORMANT Frances Fletcher		Address Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage DUE TO (b) Shot gun wound abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH Instant Instant			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by shotgun (Homicide)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 7:30PM 10/15/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Cambridge Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 10/19/67	
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial	23b. DATE THEREOF 10/21/67	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City or Town) (County) (State) Cambridge, Dor. Md.
24. FUNERAL DIRECTOR Fredrick C. DeBair		ADDRESS Cambridge, Md.	
25a. REC'D BY REGISTRAR DATE OCT 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13828

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		d. STREET ADDRESS RFD. #3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nicie Woolford Payne		4. DATE OF DEATH Month Oct. Day 8, Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1903
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Woolford		14. MOTHER'S MAIDEN NAME Catherine Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-07-9443		16. SOCIAL SECURITY NO. 214-07-9443	
17. INFORMANT Gladys Palmer		Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture cerebral aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>		22. DATE SIGNED 10/13/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY Christ Rock,	23d. LOCATION (City or Town) (County) (State) Dorchester County, Md
24. FUNERAL DIRECTOR <i>Frederick C. [Signature]</i>		25a. REC'D BY REGISTRAR OCT 17 1967	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13824

13829

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Church Creek	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 09-1	
3. NAME OF DECEASED (Type or print) Rómie Phillips		4. DATE OF DEATH Month Oct. Day 7 Year 19 67	
5. SEX Male	6. COLOR OR RACE Ngrp	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1898
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hoseph Phillips		14. MOTHER'S MAIDEN NAME Eliza Travers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 212-16-7374	
17. INFORMANT Rachel Phillips		Address Church Creek, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 30 Mins.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>		22. DATE SIGNED 10/11/67	
ACTUAL SIGNATURE John Mace Jr. M.D. EXAMINER'S NAME (Type) John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/11/67 Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/67	
23c. NAME OF CEMETERY OR CREMATORY Linas Road Cemetery		23d. LOCATION (City or Town) (County) (State) Dorchester Co., Md.	
24. FUNERAL DIRECTOR Edwin C. Deane ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR OCT 17 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13825

13830

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN Tb <u>50 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Zion Methodist Church</u>		d. STREET ADDRESS <u>404 Linden Ave.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Daisy</u> Last <u>Ralph</u>		4. DATE OF DEATH <u>Oct. 29, 1967</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1885</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>09</u> Days <u>1</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laurel, Del</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James L. Ralph</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Goslee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family Records</u>	
17. INFORMANT <u>Family Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		22. DATE SIGNED <u>10/30/67</u>	
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Md.</u>	
24. FUNERAL DIRECTOR <u>James R. Thorne</u> ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 6 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13826

13831

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN lb 2 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS Box 24A	
3. NAME OF DECEASED (Type or print) ESTHER First Middle Last L RANKIN		4. DATE OF DEATH Month OCTOBER Day 3 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-15-30
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JORDAN RANKIN		14. MOTHER'S MAIDEN NAME ANNA TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT RECORDS OF THE EASTERN SHORE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 465X Pulmonary embolism IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) 2 hours. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post-pancreatectomy diabetes - Bowel fistula, post-operative			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE E. Fernandez		22b. DATE SIGNED OCT. 4 1967	
22c. PHYSICIAN'S NAME (Type) EFRAIN C. FERNANDEZ		22d. ADDRESS E. S. S. Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/9/67	23c. NAME OF CEMETERY OR CREMATORY UNION	23d. LOCATION (City or Town) (County) (State) CHESTER KENT MD.
24. FUNERAL DIRECTOR Julius C. Allen		25a. REC'D BY REGISTRAR CAMBRIDGE, MD.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 11 1967	

1388

DEPARTMENT OF HEALTH

1900

CONCESSION

MARYLAND

QUEEN ANNE

LAKEVIEW (HURST)

3 MONTHS

CHESLEY

EASTERN SHORE STATE HOSPITAL

2 BOX 200

EASTERN

WALKIN

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WALKIN

NORTH CAROLINA

JORDAN HALL

WALKIN

NO

RECORDS OF THE EASTERN SHORE STATE HOSPITAL

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13832

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> 202	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>205 Davis Ave.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Curtis C. Satchell, Jr.</u>		4. DATE OF DEATH Month <u>10/1</u> Day <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/1920</u>
9. AGE (In years last birthday) yrs. <u>46</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Curtis C. Satchell, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-20-6049</u>	
17. INFORMANT <u>Mrs. Curtis C. Satchell, Jr.</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra abdominal hemorrhage</u> 823.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which hit pole.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:30</u> <u>10/1/67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Glasgow St.</u>	20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.		22. DATE SIGNED <u>10/3/67</u>	
EXAMINER'S NAME (Type) <u>John Mace Jr. Md.</u>		Address (Street, city, town, or county) <u>Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>MAURICE E. NEUNAM & SON, Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13822		13833	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS R.F.D. #1	
3. NAME OF DECEASED (Type or print) First CARRIE Middle SIMMONS Last SIMMONS		4. DATE OF DEATH Month October Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1922
9. AGE (In years lost birthday) yrs. 45		10. IF UNDER 1 YEAR Months 45 Days 45 Hours 45 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Lenore County, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Broadie Whitfield		14. MOTHER'S MAIDEN NAME Narcissus Joyner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 239-16-6313	
17. INFORMANT Frank Simmons, East New Market, Md., RFD #1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Hypertensive DUE TO (c) Arteriosclerotic cardiovascular renal disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1967 , to Oct. 8, 1967 , that (I) (we) last saw the deceased alive on Oct. 8, 1967 , and that death occurred at 3 P.M. , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED Oct. 10, 1967	
22c. PHYSICIAN'S NAME (Type) J. EDWIN FASSETT, M.D.		22d. ADDRESS 623 High Street, Camb., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF October 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery	23d. LOCATION (City or Town) (County) (State) Near Rhodesdale, Md.
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.		25a. REC'D BY REGISTRAR OCT 20 1967	25b. REGISTRAR'S SIGNATURE

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UNITED STATES OF AMERICA

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Cambridge - Dorchester

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Negro

Female

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Marion County, N.C.

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Marion County, N.C.

Marion County, N.C.

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Franklin County, N.C.

Marion County, N.C.

October 10, 1963

Female

1963

Marion County, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13829

CERTIFICATE OF DEATH

13834

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg - Rural		c. LENGTH OF STAY IN lb 8 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		d. STREET ADDRESS St. Mary's Nursing Home	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLYDE SPENCER		4. DATE OF DEATH Month October Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1900
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (County & State, or foreign country) Valdosta, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Times Spencer		14. MOTHER'S MAIDEN NAME Lena Nathan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 364-20-1015	
17. INFORMANT Mrs. Lena Spencer, Coraopolis, Penna.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Congestive failure DUE TO 443X (b) Hypertensive Arteriosclerotic heart Disease DUE TO 10yrs (c) Artierosclerosis Generaliazed 20yrs		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilaterally Blind		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/27/67 , 19 19 , to 10/26/67 , 19 19 , that (I) (we) last saw the deceased alive on 10/25/67 , 19 19 , and that death occurred at 7 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Harold B. Plummer		22b. DATE SIGNED 11/1/67	
22c. PHYSICIAN'S NAME (Type) harold B. Plummer		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 31, 1967	
23c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		23d. LOCATION (City or Town) (County) (State) Near Hurlock, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Leah N. Klevor

Time spent

Journal of Interpersonal Violence 26(10)

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1/65
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13830					13835					
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN ID 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Md. Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison d. STREET ADDRESS 09-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Philip Middle Hamilton Last Travers			4. DATE OF DEATH Month October Day 8 Year 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1904		9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Dorchester Md.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Lake R. Travers					14. MOTHER'S MAIDEN NAME Mary Thomas					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 220-16-986		17. INFORMANT Address Mrs. P. Hamilton Travers Madison Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER 1810 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO METASTASIS TO PELVIS & BOWEL (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 10 Mos.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from DEC 5, 1966 , to OCT 8, 1967 , that (I) (we) last saw the deceased alive on OCT 8, 1967 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Alfred R. Maryanov					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/9/67			
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV					22d. ADDRESS 610 RACE ST, CAMBRIDGE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 10-11-67		23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM-PARK			23d. LOCATION (City, town or county) (State) CAMBRIDGE MD.		
24. FUNERAL DIRECTOR Kenneth R. Thomas Jr.					ADDRESS CAMBRIDGE MD.		25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13831

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13836

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last TREGOE		4. DATE OF DEATH Month Oct. 30, Day 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1893
9. AGE (In years) 74 birth day		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Dirt-Timber	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William L. Tregoe		14. MOTHER'S MAIDEN NAME Ida Gore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 1		16. SOCIAL SECURITY NO. 220-15-9970	
17. INFORMANT Harold Jones, 1553 Doxbury Road, Towson, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. M.D.		22. DATE SIGNED 11/2/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY Joppa Churchyard		23d. LOCATION (City or Town) (County) (State) Madison, Dor. Co., Maryland	
24. FUNERAL DIRECTOR LeCompte Funera l Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR DATE NOV 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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STANDARD FORM NO. 64

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13832

CERTIFICATE OF DEATH

13837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 yos 9 mos 2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		09-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Melinda</u> Last <u>White</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1882</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Livi K. Killion</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Seymour</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>216-56-0753</u>	
17. INFORMANT <u>Med. Records</u>		Address <u>Eastern Shore State Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PYELONEPHRITIS</u> DUE TO (c) <u>CHRONIC BRAIN SYNDROME</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETIS MELLITIS + ARTERIOSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 6</u> , 19 <u>67</u> , to <u>OCT 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT 7</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Sean M. Killoran</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Sean M. Killoran</u>		22d. ADDRESS <u>Cambridge Hall Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City or town) (County) (State) <u>Easton</u> <u>Talbot</u> <u>Md</u>	
24. FUNERAL DIRECTOR <u>John A. ...</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

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1-12-31

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

13832

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13838

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 10 Min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS R.F.D. 2	
3. NAME OF DECEASED (Type or print) Joshua First Middle Last		4. DATE OF DEATH 10-6-67 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1918 9. AGE (In years last birthday) yrs. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Queen Anne Co., Md.
13. FATHER'S NAME Joshua Wilkins		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Susie Harris	
16. SOCIAL SECURITY NO. 213-24-1525		17. INFORMANT Dorothy Wilkins Rt.2, Box 241, Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand Mal seizure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary occlusion DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hour ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 10/8/67			
23a. BURIAL, CREMATION, or OTHER FINAL DISPOSITION Burial	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY Carmicheal	23d. LOCATION (City or Town) (County) (State) Queen Anne, Md.
24. FUNERAL DIRECTOR Dashiell Funeral Home, Easton, Maryland		25a. REC'D BY REGISTRAR DATE OCT 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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Amelia

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Combridge-Harvard Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

3640 13834		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13839	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Cambridge, MD</u>		c. LENGTH OF STAY IN lb <u>9 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman - Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13 EASTERN Shore State Hospital</u>		d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>S. HOWARD</u> First Middle Last <u>Willey</u>		4. DATE OF DEATH Month <u>10</u> Day <u>25</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-24-89</u>	9. AGE (In years lost birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATER MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEAVITT, MARYLAND</u>	
13. FATHER'S NAME <u>SAMUEL Bush Willey</u>		14. MOTHER'S MAIDEN NAME <u>ELLA Willey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-10-6583 A</u>		17. INFORMANT Address <u>medical Record CHART E.S.S.H</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Bronchopneumonia due to aspiration of vomit</u> DUE TO (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <u>Felipe M. Dominguez</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ</u>		22d. ADDRESS <u>E.S.S.H</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/27/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>METHODIST</u>	
23d. LOCATION (City or Town) (County) (State) <u>TILGHMAN, MD.</u>					
24. FUNERAL DIRECTOR <u>Maurice E. Newman & Son</u>		ADDRESS <u>KATOW, MD</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13835

CERTIFICATE OF DEATH

13840

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY	
c. LENGTH OF STAY IN 1b 1 WEEK		d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jacob ROLLIE First Middle Last		4. DATE OF DEATH OCTOBER 6 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/78
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ANDREW WILLOUGHBY		14. MOTHER'S MAIDEN NAME EMILY - Willoughby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-54-5731 J1	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 6000 Uremia IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Chronic pyelonephritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 28, 1967 , to October 6, 1967 , that (I) (we) last saw the deceased alive on October 6, 1967 , and that death occurred at 2:45 AM, from causes and on the date stated above.			
22a. SIGNATURE Carlos F. Barroso M.D.		22b. DATE SIGNED OCTOBER 6-67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO		22d. ADDRESS HURLOCK MD	
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE THEREOF 10-8-67	
23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City or Town) (County) (State) Greensboro, Maryland	
24. FUNERAL DIRECTOR J.C. Boulaire		25a. REC'D BY REGISTRAR 1967	
ADDRESS Greensboro, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13836					13841				
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY IN 1b <u>33 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			d. STREET ADDRESS <u>125 Maryland Ave.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>125 Maryland Ave.,</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>Tolley</u> Last <u>Windsor</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 5, 1914</u>		9. AGE (In years last birthday) <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Hoopersville, Dor. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Coldsborough Tolley</u>					14. MOTHER'S MAIDEN NAME <u>Grace Phillips</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>1621</u>		17. INFORMANT <u>George A. Windsor, Cambridge, Md.</u>		Address <u>125 Maryland Ave.,</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIOGENIC CARCINOMA</u> DUE TO <u>METASTASIS TO SPINE & PERICARDIUM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 21, 1967</u> to <u>OCT 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>OCT 6, 1967</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Alfred R. Maryanov</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>					22d. ADDRESS <u>610 RACE ST, CAMBRIDGE MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Md.</u>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>Samuel D. Thoreau</u>					ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 8 & 9 Film G595 11/21/67 KK											
13837					13842						
1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>			c. LENGTH OF STAY IN 1b <u>4 mos. 8 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON (RURAL)</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>					d. STREET ADDRESS <u>RT 1 Box 263</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>ROSELLE</u> Last <u>WRIGHT</u>					4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-08-12A/1923</u>		9. AGE (In years last birthday) <u>44 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ELON WRIGHT</u>					14. MOTHER'S MAIDEN NAME <u>MARY D. WRIGHT</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>EASTERN SHORE STATE HOSPITAL</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA (LEFT LOWER LOBE)</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>SEIZURE DISORDER</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HURLER'S SYNDROME</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>06-13</u> , 19 <u>67</u> , to <u>OCT 21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>OCT 21</u> 19 <u>67</u> , and that death occurred at <u>7:30 A</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Sean M. Killoran</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 21, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>SEAN M. Killoran</u>					22d. ADDRESS <u>EASTERN SHORE STATE HOSP.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>OCT 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>			23d. LOCATION (City or Town) (County) (State) <u>DENTON MD.</u>				
24. FUNERAL DIRECTOR <u>CHARLES MOORE</u>					ADDRESS <u>DENTON</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Moore</u>		

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